(Pre-2007 multiple primary/histology rules are used for all sites except CNS)

Case 1: Lung

Physical Examination

9/11 This 75-year-old male patient presented with symptoms of pneumonia, complaints of back pain, and periods of confusion. No other abnormalities.

Imaging

9/11 Chest X-ray: Right upper and right lower lobe pneumonia. No adenopathy seen.

9/13 Bone scan: Increase uptake at L3 and L5.

10/5 MRI brain: Diffuse cerebral atrophy.

Procedures

9/11 Fibroscopic ENT exam: No lesions seen in oral cavity, oropharynx, hypopharynx or larynx.

9/12 Bronchoscopy with biopsy: Right mainstem bronchus occluded with clots. Mass on carinal side of right mainstem bronchus (non-resectable).

Pathology

9/12 Mainstem bronchus biopsy: Poorly differentiated non-small cell carcinoma. Comment: Features best fit with squamous cell carcinoma or adenosquamous cell carcinoma. Mucin stains are negative. Bronchial washings: malignant cells.

Answers

Case 1 Lung	Answer	Rationale
Date of Dx	9/12	Bronchoscopy with biopsy; *FORDS,* p. 89
Primary Site	C34.0	Bronchoscopy with biopsy; *FORDS,* p. 91
Laterality	1	Bronchoscopy with biopsy; *FORDS,* p. 92
Histology	8046/33	Path, bronchoscopy with biopsy; *FORDS,* p. 93; "features best fit with squamous cell carcinoma or adenosquamous cell carcinoma", no rule to decide which to use, better to default to non-small cell carcinoma
CS Extension	21	Bronchoscopy with biopsy; *Collaborative Staging (CS) Manual,* p. 404, distance from carina, NOS, and no surgery
CS Lymph Nodes	00	Chest X-ray; *CS Manual,* p. 407
CS Mets at Dx	99	Bone scan non-specific; *CS Manual,* p. 409
Surg Primary Site	00	*FORDS,* p. 264
Scope Reg LN Surg	0	*FORDS,* p. 138
Surg Proc/Other Site	0	*FORDS,* p. 142
Rad Reg Treatment Mod	00	*FORDS,* p. 155
Chemotherapy	00	*FORDS,* p. 171
Hormone Therapy	00	*FORDS,* p. 175
Immunotherapy	00	*FORDS,* p. 179
Hem Tsplt & End Proc	00	*FORDS,* p. 183
Other Treatment	0	*FORDS,* p. 186

Case 2: Lung

Physical Examination

5/12 X-ray work-up for history of back pain positive for lung malignancy with bone metastasis. Paraspinal tenderness over areas of known tumor involvement.

Imaging

5/3 Chest X-ray: Right upper lobe mass confined to lung; bilateral pleural masses; malignancy suspected.

5/3 CT chest: Bone destruction posterior ribs/spine.

5/4 Bone scan: Diffuse bone mets

Pathology

5/12 Left rib FNA biopsy: Probably adenocarcinoma, focally bronchiolo-alveolar.

Oncology

6/1 Received radiation to spine for palliation.

Answers

Case 2 Lung	Answer	Rationale
Date of Dx	5/3	Chest X-ray; *FORDS,* p. 89
Primary Site	C34.1	Chest X-ray; *FORDS,* p. 91
Laterality	1	*FORDS,* p. 92
Histology	8140/39	FNA biopsy; *SEER Program Coding and Staging Manual (PCSM) 2004,* p. 87, histology coding rules for single tumor #6
CS Extension	76	Chest X-ray, pleural masses not direct extension; *Collaborative Staging (CS) Manual,* p. 406
CS Lymph Nodes	99	*CS Manual,* p. 407; inaccessible site rule does not apply because it is not early stage disease
CS Mets at Dx	40	Left rib FNA biopsy; *CS Manual,* p. 409
Surg Primary Site	00	*FORDS,* p. 264
Scope Reg LN Surg	0	*FORDS,* p. 138
Surg Proc/Other Site	0	*FORDS,* p. 142
Rad Reg Treatment Mod	20	*FORDS,* p. 155
Chemotherapy	00	*FORDS,* p. 171
Hormone Therapy	00	*FORDS,* p. 175
Immunotherapy	00	*FORDS,* p. 179
Hem Tsplt & End Proc	00	*FORDS,* p. 183
Other Treatment	0	*FORDS,* p. 186

Case 3: Lung

Physical Examination

4/27 Lungs have coarse breath sounds with scattered rhonchi.

Imaging

4/27 Chest X-ray: Left lower lobe infiltrate and pleural effusion.

4/27 CT chest: Right upper lobe mass extending to pleural-based lesion involving left upper lobe.

4/29 Bone scan: Negative.

11/16 CT brain: Consistent with metastasis.

Pathology

4/28 Left lower lobe and left mainstem bronchus biopsies: Undifferentiated small cell carcinoma (oat cell type)

4/28 Washings, bilateral lungs: Suspicious for malignancy

Oncology

Recommended combination chemotherapy, etoposide and cisplatin. Patient received first treatment on 5/15.

Answers

Case 3 Lung	Answer	Rationale
Date of Dx	4/28	Biopsy; *FORDS,* p. 89
Primary Site	C34.1	CT chest, indicates mass located in RUL & extends to pleura involving LUL; *FORDS,* p. 91
Laterality	1	CT chest; *FORDS,* p. 92
Histology	8042/34	Biopsy path; *SEER Program Coding and Staging Manual (PCSM) 2004,* p. 87, histology coding rules for single tumors #6
CS Extension	72	Chest X-ray, pleural effusion; *Collaborative Staging (CS) Manual,* p. 405
CS Lymph Nodes	99	*CS Manual,* p. 407; inaccessible sites rule does not apply because it is not early stage disease
CS Mets at Dx	39	Left lung biopsies & CT chest, RUL mass extends to pleura & then to LUL; *CS Manual,* p. 409
Surg Primary Site	00	*FORDS,* p. 264
Scope Reg LN Surg	0	*FORDS,* p. 138
Surg Proc/Other Site	0	*FORDS,* p. 142
Rad Reg Treatment Mod	00	*FORDS,* p. 155
Chemotherapy	03	*FORDS,* p. 171
Hormone Therapy	00	*FORDS,* p. 175
Immunotherapy	00	*FORDS,* p. 179
Hem Tsplt & End Proc	00	*FORDS,* p. 183
Other Treatment	0	*FORDS,* p. 186

Case 4: Lung

History and Physical Examination

10/28 Patient is a 51-year-old male with history of T4N3 squamous cell carcinoma of tonsil status post concurrent chemoradiation finished in October two years ago. He was hospitalized recently locally for a pneumonia and a chest X-ray showed a mass in the right lower lobe. He was evaluated by his otolaryngologist, and a PET study and chest CT were obtained. He is here today for further evaluation. He reports shortness of breath for years, although it is somewhat worse through his tracheostomy. He states he can remove his trach tube with some improvement in shortness of breath. Most of the time this is a fairly stable symptom. He has a longstanding cough and reports mild hemoptysis when he has a very harsh cough. His last episode was approximately two years ago. He has not required O2 therapy and he denies wheezing. He denies orthopnea, paroxysmal nocturnal dyspnea, and he has no chest pain. He smoked two packs a day for approximately 30 years and quit at the time of his head and neck cancer diagnosis. All other systems are negative.

Imaging

10/6 PET, F-18FDG Tumor Imaging: There are no hypermetabolic foci in the oropharynx, neck or mediastinum. There is a 2.5 cm right lower lobe lateral basal segment mass with maximum SUV of 5.5. In retrospect, there is a smaller 1 cm nodule at this site on the previous PET from 2/27 with maximum SUV of 3.3. Impression: Right lower lobe mass consistent with a second primary vs. metastatic lung lesion. No other foci are appreciated.

10/6 CT Chest: Findings: Supraclavicular, axillary, and mediastinal structures are unremarkable other than the presence of a tracheostomy tube. No mediastinal or hilar adenopathy are present. There is a lobulated 2.8 x 2.4 x 3 cm noncalcified soft tissue mass in the lateral basal segment of the right lower lobe. The margins are well defined with minimal peripheral ground-glass opacity, probably some degree of obstructive pneumonitis. The second 2 x 5 mm noncalcified soft tissue nodule is present in the medial aspect of the posterior segment of the right upper lobe. The remainder of the lungs is clear.

Impression

1. Lobulated soft tissue mass in the right lower lobe is consistent with neoplasm. Whether metastatic or primary lung is unclear. No evidence of adenopathy, mediastinal or hilar spread.

2. Nonspecific soft tissue nodule in the right upper lobe. This is nonspecific but by itself would be consistent with benign parenchymal scar or granuloma. However given the probable neoplasm in the right lower lobe, a secondary focus, a neoplasm should be considered.

11/11 CT, Brain with and without contrast: Mild parenchymal volume loss otherwise unremarkable study.

Procedures

11/23 1. Fiberoptic bronchoscopy. 2. Right lower lobectomy. Findings: No endobronchial lesions were seen on bronchoscopy. The mass was well circumscribed by normal right lower lobe pulmonary tissue. There was no pleural effusion, no pleural nodules or adhesions. No upper or middle lobe nodules were present. There was no suspicious lymphadenopathy. During the dissection multiple lymph nodes were identified and were included with main specimen. The mediastinal lymph node region was dissected and representative lymph nodes were included. These appeared to be uninvolved by disease.

Pathology

11/23 Gross: A) Right lower lobe of lung. There is a well-circumscribed yellow, soft necrotic round mass located approximately 0.1 cm from the nearest pleural margins and distant from the bronchial margin in the lower lobe of right lung. Tumor size is 5.0 x 3.2 x 1.8 cm. No vessel involvement. No bronchial involvement. Extends up to 0.1 cm from the visceral pleura but does not grossly involve it. Three small black hilar lymph nodes are identified and are grossly negative. B) Probable lymph node. C) Gray round soft tissue fragment. D) Probable node. E) Gray tan soft tissue fragment. Specimen appears consistent with lung. Grossly no tumor identified. F) Yellow white soft tissue fragment consistent with fat and soft tissue.

Microscopic: A) Sections show proliferating squamous cell in a haphazard pattern invading lung tissue and growing within the conducting airways. There is nuclear pleomorphism and atypia, however, squamous cell differentiation is still identifiable. Invasive squamous cell carcinoma, moderately differentiated. Tumor cells are identified within the tertiary bronchi and large bronchioles. Does not invade the pleura. Tumor cells appear to surround the vasculature but no definite invasion is identified. No perineural invasion is seen. Suspicious for vascular invasion but no definite invasion. Three hilar lymph nodes negative.

Diagnosis

A. Lung, right lower lobe, lobectomy: moderately differentiated squamous cell carcinoma, 5.0 cm in greatest dimension, not involving the pleura. No definite vascular, lymphatic, or perineural invasion identified. Mild emphysematous changes. Lymph nodes, hilum lobectomy: no tumor identified in three lymph nodes (0/3).

B. Lymph node, no tumor identified (0/1).

C. Lymph node, no tumor identified (0/1).

D. Lymph node, no tumor identified (0/1).

E. Lung, right, additional superior segment, resection: mild emphysematous changes.

F. Lymph node, no tumor identified (0/1).

Oncology

12/30 This is a 51-year-old man who had been a 60-pack year smoker. He has no exposure to asbestos or radiation and no family history of lung cancer. Two years ago he had a squamous cell cancer of the tonsil that was T4N3. He was treated with bid fraction radiation and what appears to have been two cycles of cisplatin 100 mg/m2. He has not been able to swallow since that therapy and is fed with a gastrostomy tube and had a permanent tracheostomy. On 11/23 he had a right lower lobe lobectomy for a non-small cell lung cancer. He had negative nodes and a 5 cm cancer. This would be a T2N0M0 cancer or stage 1B. IN CALGB 9633 presented at ASCO, there was a 12% improvement in survival for this stage of disease for patients receiving 4 cycles of adjuvant taxol and carboplatin. I have recommended this to the patient, but he would rather receive this therapy closer to home. He has been referred to an oncologist closer to home and will see him about the CALGB regimen.

Answers

Case 4 Lung	Answer	Rationale
Date of Dx	10/6	PET; *FORDS,* p. 89
Primary Site	C34.3	Lobectomy; *FORDS,* p. 91
Laterality	1	Chest CT; *FORDS,* p. 92
Histology	8070/32	Lobectomy path; FORDS p. 93
CS Extension	40	Chest CT, obstructive pneumonitis; *Collaborative Staging (CS) Manual,* p. 404
CS Lymph Nodes	00	Lobectomy path; *CS Manual,* p. 407
CS Mets at Dx	00	PE, all other systems negative; *CS Manual,* p. 409
Surg Primary Site	33	Lobectomy path, mediastinal LNs dissected; *FORDS,* p. 264
Scope Reg LN Surg	5	Lobectomy path, 7 regional LNs removed; *FORDS,* p. 139
Surg Proc/Other Site	0	*FORDS,* p. 142
Rad Reg Treatment Mod	00	*FORDS,* p. 155
Chemotherapy	88	*FORDS,* p. 172
Hormone Therapy	00	*FORDS,* p. 175
Immunotherapy	00	*FORDS,* p. 179
Hem Tsplt & End Proc	00	*FORDS,* p. 183
Other Treatment	0	*FORDS,* p. 186

Case 5: Lung

History and Physical Examination

Date of Admission: 6/24/XX

Chief Complaint: Hemoptysis

History of Present Illness: The patient is a 57-year-old Hispanic male with no significant previous medical history. He was born in Puerto Rico and moved to the United States at age 3. He lived in a heavily Hispanic area most of his life. He states that over the last two years he has also been in and out of homeless shelters as well. He has recently been traveling through the Midwest looking for work. He had been a two pack per day smoker for 40 years and quit three years ago. He states that approximately six months ago he developed a productive cough of brown sputum. Then approximately one month ago he developed hemoptysis. Today he presented to the Emergency Department because he had increase in hemoptysis. He also feels that he has had a low-grade fever and chills for approximately one month. He has lost approximately 40 lb over the last year or so. He denies any night sweats. There is no previous history of PPD or exposure to tuberculosis. The patient denies any alcohol use or street drug use. The patient denies any frequent respiratory infections in the past. There is no chest pain or tightness. There is no wheezing. He does complain of some sore throat, especially on the right side of his neck. There is no dysphagia. There are no recurrent joint symptoms, muscle aches, or rashes. There is no focal weakness or numbness. There is no nausea or vomiting, diarrhea, or constipation. There is no leg swelling. There is no PND or orthopnea.

Past Medical History: As above.

Medications: None

Allergies: No known drug allergies

Social History: As above.

Family History: Alzheimer's and lung carcinoma.

Review of Systems: As in history of present illness. In addition, he denies any headaches, dizziness, or light-headedness. There is no focal weakness or numbness. There is no visual change. There is no sinus complaint. There is no abdominal pain. There is no dysuria or hematuria. There is no melena or hematochezia. There is no heat or cold intolerance. His mood is good.

Physical Examination: Revealed a Hispanic male in no significant respiratory difficulty.

Vital Signs: Temperature 38.4. Pulse 97. Respirations 16. Blood pressure 136/78. 02 Saturation is 94% on room air.

Skin: No rashes.

HEENT: Clear conjunctivae. Pupils equal, round, and reactive to light. Nasal passages were clear without drainage. Oropharyngeal mucosa moist without erythema or exudates.

Neck: Supple with full range of motion. There is mild tender adenopathy in the right submandibular area. There is no jugular venous distention. There is no thyromegaly. Trachea is midline.

Chest: Symmetrical respiratory excursions. There is no hyperexpansion, hyperresonance, dullness to percussion, or chest wall tenderness.

Lungs: Rhonchi over the right upper lung zone. There is no wheezing or crackles. There are no bronchial breath sounds or pleural rub.

Heart: Regular rhythm. Normal S1 and S2 without murmurs or gallops.

Abdomen: Soft, non-tender, non-distended without hepatosplenomegaly or masses. Normal bowel sounds present.

Extremities: Without cyanosis, clubbing, edema, or tenderness. Pulse 2+. Joints without swelling. There is no lymphadenopathy.

Neurologic: The patient is alert and oriented times three. He was in good spirits. Motor is 5/5. Gait is normal.

Laboratory Data: Laboratory data is only remarkable for a white count of 23.9, hemoglobin 8.2, hematocrit 27, MCV 77.7, platelets 748. Chest X-ray showed large right upper lung density.

Assessment: Pneumonia. We will need to consider tuberculosis, coccidioidomycosis, post-obstructive pneumonia with possible lung carcinoma.

Plan

1. Culture.
2. IV Antibiotics.
3. Sputum gram stain and culture, AFB and fungal smear on culture.
4. CT of the chest
5. PPD
6. Respiratory isolation
7. The patient may need a bronchoscopy as well.

Chest CT Without and With IV Contrast (Case 5: Lung)

Date: 6/25/XX

Indication: Abnormal chest X-ray.

Findings: Correlation is made with the chest film. I see no pneumothorax or pleural effusion. There is a 11.7 x 8.5 soft tissue mass in the right apex. This shows nonhomogeneous enhancement. There is associated marked mediastinal lymphadenopathy with enlarged nodes in the anterior mediastinum, enlarged nodes lying lateral to the main pulmonary artery, and enlarged nodes in the pretracheal and precarinal region. There are enlarged nodes around the right hilum and to a lesser degree in the azygoesophageal recess. There is some distal infiltrate in the right upper lobe and also in the right middle lobe. There is some narrowing of the right upper and right middle lobe bronchi. The right lower lobe bronchus appears intact.

I see no significant axillary lymphadenopathy.

Conclusion: Right upper lobe mass with associated marked mediastinal lymphadenopathy. The findings are highly suspicious for a primary carcinoma of the lung. This mass should be amenable to CT guided percutaneous biopsy if clinically indicated.

Operative Report (Case 5: Lung)

Date of Admission: 6/24/XX

Date of Procedure: 6/26/XX

Procedure Performed: Fiberoptic bronchoscopy with endobronchial biopsy.

Indication: Right upper lobe mass.

Pre-Procedure Diagnosis: Right upper lobe mass

Post-Procedure Diagnosis: Right upper lobe mass.

After the risks and benefits of the procedure including hemorrhage, pneumothorax, respiratory depression, hypotension were explained to the patient, he underwent fiberoptic bronchoscopy in the endoscopy suite. He received pre-medication with Fentanyl and Atropine. He received nebulized Lidocaine, Cetacaine spray, viscous Lidocaine to the nasal and oropharynx for topical anesthesia. He received Versed a total of 5mg IV for sedation.

The bronchoscope was passed orally without difficulty. The vocal cords were visualized and appeared to move normally. The bronchoscope was passed to the trachea, which was widely patent. The trachea divided to the right and left mainstem bronchi. The left mainstem bronchus divided to the left upper lobe lingual and left lower lobe. No pus, heme, endobronchial lesions were noted. The right mainstem bronchus divided to the right upper lobe, right middle lobe, right lower lobe. No pus, heme, endobronchial lesions were noted at the right lower lobe or right middle lobe. The right upper lobe orifice was narrowed with heaped up mucosa. There was a small amount of bleeding from the right upper orifice. Past the initial abnormal mucosa the three major segments of the right upper lobe could be visualized. However, the mucosa continued to have an abnormal appearance. It was somewhat difficult to determine which segment had a small amount of bleeding coming from it. Endobronchial biopsy was performed times six at the right upper lobe. Bleeding was minimal. The patient remained with oxygen saturation 88 or greater, sinus rhythm, and stable blood pressure throughout the procedure.

Pathology Report (Case 5: Lung)

Date: 6/26/XX

Specimen(s)

Right lower lobe of lung-CT guided biopsy

Post-Operative Diagnosis

Right upper lobe mass with marked lymphadenopathy (mediastinal) suspicious for primary carcinoma of lung.

Diagnostic Opinion

Extensively necrotic tumor tissue with preserved cells consistent with non-small cell carcinoma, CT guided right lung biopsy, see description.

Clinical History

Cough times 6 months. In and out of homeless shelter 2 years, developed hemoptysis times 1 month, weight loss, low-grade fever with chills times 1 month.

Gross Description

Specimen labeled “right upper lobe of lung CT guided biopsy” consists of ten tiny fragmented portions of tissue measuring much less than 0.1cm each. Attempts will be made to section the specimen. All for section.

Microscopic Description

Sections reveal portions of apparent tissue with extensive necrosis. However, the shadowy cells are of fair size with occasional suggestion of prominent nucleoli. There are several focal areas of preserved nuclei noted with eosinophilic cytoplasm. The general feature is highly consistent with non-small cell carcinoma with extensive necrosis. Clinically, patient had cough for six months and also hemoptysis, weight loss, low-grade fever for about a month. On X-ray study, there was a large lung mass in the right apex measuring 11.7 x 8.5cm with marked mediastinal lymphadenopathy. The general feature is that of lung carcinoma, non-small cell type with extensive necrosis most likely with metastasis in the mediastinal lymph node. Further clinical correlation and follow-up are recommended. The case has been reviewed by members of the department.

Final Diagnosis: Necrotic, non-small cell carcinoma.

Oncology Consultation (Case 5: Lung)

6/27/XX

Reason for Consultation: New diagnosis of non-small cell lung cancer.

History of Present Illness: Patient is a 57-year-old Hispanic gentleman with heavy smoking in the past. He came to the hospital with a six-month history of cough and intermittent hemoptysis. Subsequently, a work-up showed the patient had a right upper lobe mass with a marked mediastinal lymphadenopathy, including a subcarinal node, on the CT Scan. Biopsy of this lesion showed a non-small cell lung cancer with quite extensive necrotic tissue. Lab findings found a white blood cell count of 23,1000, hemoglobin 8.1, platelet count 766,000, MCV 78.7. Sedimentation rate was 116. Comprehensive metabolic profile was within normal limits.

The patient denies any bone pain, nausea and vomiting, dizzy spells, headache, or seizure.

Past Medical History: Unremarkable.

Past Surgical History: A gunshot wound in the past.

Medications: None.

Allergies: No known drug allergies.

Social History: The patient was born in Puerto Rico and moved to the United States when he was very young. Mostly he lived in a Hispanic area. He has been homeless and he is looking for a job throughout the Midwest. At this time, the patient does not have any place to stay.

Review of Systems: As above.

Physical Examination

General: The patient does not have any respiratory distress, but he has frequent coughing.

Vital Signs: Stable. The patient is aferbrile.

HEENT: Conjunctiva pale.

Lungs: Clear.

Heart: Regular rate and rhythm, without murmur.

Abdomen: Soft and non-tender. Bowel sounds are present. No hepatosplenomegaly, no palpable masses.

Extremities: Full range of motion in all extremities. No clubbing, cyanosis, or edema.

Neurologic: Examination within normal limits, without any focal neurological deficits.

Assessment: The patient is a 57-year-old gentleman with heavy smoking in the past, now presently with a right upper lobe mass and mediastinal lymphadenopathy. Biopsy showed non-small cell carcinoma. The patient now has symptoms of hemoptysis and resultant iron deficiency anemia.

The patient has at least Stage 3b disease. This condition can best be treated with a combination of chemotherapy and radiation therapy concurrently. I discussed this information with the patient. I would like to have a radiotherapy consultation with Dr. X about this. We want to start treatment as soon as possible.

Discharge Summary (Case 5: Lung)

Date of Admission: 6/24/XX

Date of Discharge: 7/1/XX

Discharge Diagnoses

1. Locally advanced non-small cell lung cancer.
2. Hemoptysis.
3. Iron deficiency anemia.
4. Respiratory symptoms with coughing and shortness of breath.

Summary: Patient is a 57-year-old gentleman with a diagnosis of non-small cell lung cancer. This is stage 3B disease, and is non-small cell cancer with quite extensive necrotic tissue. Because of shortness of breath, coughing, hemoptysis, and subsequent iron deficiency anemia, the patient has been treated with chemotherapy consisting of cisplatin and VP-16 times three days along with daily radiation therapy. During the hospital stay, the patient's overall condition has been stabilized. However, the patient does not have a place to go after discharge from the hospital. During the hospital stay, social workers were involved to find him a place to go.

Because one time the patient had an episode of emotional outburst and somewhat aggressive behavior, we checked MRI scan of the head, which was normal. At that time it was felt that the patient was not dangerous and it was most likely due to frustration and anger of his newly diagnosed cancer. Otherwise the patient's overall hospital stay was unremarkable. The patient tolerated the chemotherapy well. He was discharged from the hospital. The patient will continue to have radiation therapy daily and have chemotherapy again at the end of July.

History and Physical Examination/Consultation (Case 5: Lung)

Date of Admission: 7/28/XX

Reason for Admission: Lung cancer and chemotherapy.

History of Present Illness: The patient is a 57-year-old man with a prior history of heavy smoking who presented with hemoptysis, right heart chest pain and shortness of breath in early June. Subsequent evaluation revealed right lung mass and a biopsy of those lesions showed a non-small cell lung cancer. Because the patient already has stage 3b non-small cell cancer, patient had been treated with cisplatin, VP-16, and twice daily radiation therapy. Patient has been tolerating this very well and the patient seems to be responding to this treatment. However, because of hemoptysis, patient had iron deficiency anemia. The patient had been treated with iron pills.

Patient comes to the hospital on July 28 for further evaluation for this condition. Patient was found to have quite severe microcytic anemia due to iron deficiency anemia and is due for another round of chemotherapy. Patient intermittently is coughing, but is significantly improved.

Past Medical History: Remarkable for heavy smoking, emphysema and newly diagnosed lung cancer as mentioned above.

Medications: Include iron supplement, otherwise he is not on any medication at all.

Allergies: Patient is allergic to nothing.

Family History: Noncontributory.

Personal History: This patient lives alone and there is no smoking and no drinking at this time.

Review of Systems: He is feeling tiredness and shortness of breath on exertion and intermittently coughing and right side discomfort intermittently.

Physical Examination

Vital Signs: Stable. He is aferbrile. No acute distress.

HEENT: Pale, not icteric.

Lungs: Clear to auscultation percussion.

Heart: Regular rate and rhythm without murmur.

Abdomen: Soft, nontender. Bowel sounds are present. No hepatosplenomegaly. No palpable masses.

Extremities: Full range of motion, both extremities. No clubbing, No edema. No cyanosis.

Neurologic Examination: Within normal limits throughout and no focal neurologic deficits.

Assessment

Non-small cell lung cancer, local advanced to stage 3b disease. Patient is on chemotherapy and radiation therapy. Patient had undergone chemotherapy about a month ago and has come to the hospital again for another round of chemotherapy. The patient will receive Cisplatin and VP-16.

Answers

Case 5 Lung	Answer	Rationale
Date of Dx	6/25	Chest CT; *FORDS,* p. 89
Primary Site	C34.1	Chest CT; *FORDS,* p. 91
Laterality	1	Chest CT; *FORDS,* p. 92
Histology	8046/39	Biopsy path; FORDS p. 93
CS Extension	10	Bronchoscopy; *Collaborative Staging (CS) Manual,* p. 404
CS Lymph Nodes	20	Chest CT; *CS Manual,* p. 407
CS Mets at Dx	00	H & P, abdomen, w/o hepatosplenomegaly or masses & DS, MRI of head normal; *CS Manual,* p. 409
Surg Primary Site	00	*FORDS,* p. 264
Scope Reg LN Surg	0	*FORDS,* p. 138
Surg Proc/Other Site	0	*FORDS,* p. 142
Rad Reg Treatment Mod	20	*FORDS,* p. 155
Chemotherapy	03	*FORDS,* p. 171
Hormone Therapy	00	*FORDS,* p. 175
Immunotherapy	00	*FORDS,* p. 179
Hem Tsplt & End Proc	00	*FORDS,* p. 183
Other Treatment	0	*FORDS,* p. 186